UK trainees are the greater number of emergency medicine trained consultants in each department and the referral practices of general practitioners in Australia.

The first benefit allows increased shop floor supervision and training from experienced mentors as well as enabling professional development to proceed apace with the trainee's requirements.

The second benefit is the clinical exposure to acutely unwell medical and surgical patients that is seen in emergency departments in Australia. It is standard practice for all unwell patients seen by a GP to be referred to the emergency department for assessment and treatment. These patients are reviewed by senior staff and if required are referred to an inpatient specialty team for ongoing management. Hence trainees in Australia will be exposed to a wide variety of clinical cases throughout their training.

Current developments in the United Kingdom include an increase in the number of emergency medicine trained consultants in hospital A&E departments, thus not only improving patient care but also the training of junior doctors. The future of training in this regard would thus seem assured.

Of more concern, however, is the increase in the development of emergency referral units, whereby GPs can bypass the A&E department and refer directly to an inpatient team. These are supported on the grounds of "taking the strain off A&E". While this may decrease the number of patients seen in A&E, the case has yet to be proved that it improves either the quality or the timing of patient care. If this practice is allowed to develop unchecked then the implications for training in the United Kingdom are enormous, as trainees will see less and less non-traumatic illness during their A&E department training. Once again hospital A&E departments will have to call themselves "casualties", as trauma will be the only illness treated therein. Will we see a time when UK trainees have to go to Australia to see any acute general surgery or acute general medicine diagnosed and managed in an A&E department?

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1 Ryan JM, Gaudry PL. Opportunities for emergency medicine training in Australia. *J Accid Emerg Med* 1997;14:36-9.

Unusual complication of interhospital transfer

EDITOR,—We have recently seen an unusual complication of interhospital transfer. A six year old girl fell off a kerb onto her left elbow and attended the local accident department the same day. She was seen and had x rays of the elbow. The films were marked with a red dot as a warning by the radiographer. No abnormality was noted by the A&E junior doctor and the patient was discharged with instructions to report to the A&E department of their home town (Basingstoke) if the elbow did not improve. The unreported radiographs were given to the child's mother, but no notes.

The mother and daughter attended our department some three and a half months later, as the elbow was still painful.

Examination showed limitation of flexion, and pain on supination of the left elbow. Further radiographs were taken, which our junior doctor felt were normal. In view of the continued pain the child was asked to attend our

review clinic, and at this stage the diagnosis of a dislocated radial head was made.

Review of the x ray films showed that this was suggested on the originals (as seen by the radiographer) (fig 1) and was obvious on our second set of films. The orthopaedic team felt her injury should be managed conservatively, but if her loss of function increased then operative intervention would be needed.

Unilateral traumatic radial head dislocation is an unusual injury. It is commonly missed by inexperienced junior doctors in accident departments. Early recognition and closed reduction is the recommended management.^{1,2}

This case illustrates the problems of a poorly documented (no notes with patient) and badly instructed transfer. Even in minor injuries, when the care of the patient is being transferred to another hospital it is essential that they should have a copy of the notes and the x rays with them, as well as being given precise instructions on their attendance. If practical the hospital should be contacted and a definite arrangement made. These simple rules would have avoided the delay and potential complications for this patient, although a stoical parent is an unusual hazard in patient transfer!

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1 Lincoln TL, Mubarak SJ. Isolated traumatic radial head dislocation. *J Pediatr Orthop* 1994;14:454-7.

2 Wiley JJ, Loehr J, McIntyre W. Isolated dislocation of the radial head. *Orthop Rev* 1991;20:973-6.

Telephone survey of Diftavax use at school leaving age

EDITOR,—In 1994 the Department of Health announced the introduction of low dose diphtheria and tetanus vaccine (Td) (40 IU tetanus toxoid-4 IU diphtheria toxoid) as a replacement for the routine tetanus only booster at school leaving age.¹ This followed concerns about the re-emergence of diphtheria in the former USSR.² The diphtheria epidemic is due to waning immunity in the population (antibody to diphtheria declining with age), leaving people vulnerable to infection. Hence Td should be given to children age 10 and over³ who require antitetanus prophylaxis and have not yet received Td booster. If subjects who are 10 and over were given a tetanus only booster they could at a later date be given either a monovalent diphtheria vaccine,^{4,5} which is low dose adult vaccine, or 0.1 ml of Evans paediatric diphtheria vaccine.⁴ However, giving a child over the age of 10 years a tetanus only booster means that a diphtheria only booster has to be obtained to supplement it and the child is subject to another injection, which could be avoided.

Paediatric diphtheria and tetanus vaccine (DT) (40 IU tetanus toxoid-30 IU diphtheria toxoid) contains a higher concentration of diphtheria toxoid which can cause adverse reactions; hence Td is suggested above the age of 10 years and the paediatric diphtheria-tetanus vaccine should not be given. Also if Td is repeated within a span of one month it can cause an adverse reaction. This requires proper communication between an accident and emergency (A&E) department which gives Td and both the parents and the family doctor.

During the period December 1995 to May 1996, 25 A&E departments were assessed

Figure 1 Traumatic radial head dislocation.

randomly up and down the country with three sets of questions which were put to both medical and nursing staff. Questions were aimed to find out whether departments stocked Td and under what circumstances it was used. The following questions were asked: (1) If a 15 year old child presented to your department with a wound or burn and he had not yet received his school leaving tetanus booster would he be given a tetanus booster? (2) If yes, would he be given a tetanus only booster or the combined low dose diphtheria and tetanus vaccine?

(3) Does your department stock the low dose diphtheria and tetanus vaccine (Td)?

The results are shown in table 1.

Table 1 Results of telephone survey of Diftavax use

	Nurses	Doctors
Questions 1 & 2		
Given tetanus only booster	22	22
Given Diftavax	2	2
Refer to GP	1	1
Question 3		
Diftavax in stock:		
Yes	4	3
No	21	19
Don't know	0	3

Access to British A&E departments over the telephone was found to be difficult; however, of the 25 departments surveyed only 16% stocked Td and half of them (8%) failed to use it. This suggests that half the departments stocking Diftavax failed to recognise the indications for its use. To date, communication concerning Diftavax has been mainly in the CMO's updates and the British National Formulary. These do not appear to have been

effective ways of changing practice in A&E departments. Alternative ways and means need to be evaluated to pass on information concerning vaccination in A&E in order to improve awareness and to change practice.

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- 1 CMO's Update, 1994;2:1-2.
- 2 Department of Health. *Diphtheria in the former USSR*. (Professional letter: PL/CMO (93)9.) London: Department of Health, 1993.
- 3 British National Formulary, No 28. London: The Pharmaceutical Press, 1994.
- 4 CMO's Update, 1995;5:1.
- 5 CMO's Update, 1996;9:3.

BOOK REVIEWS

Baillière's Clinical Neurology. International Practice and Research, volume 5, number 3. Critical Care.

Edited by C F Bolton and G B Young. (Pp 245; £30.00.) London: Baillière Tindall, 1996. ISBN 0 7020 2096 6.

I believe the authors have succeeded in their aim of producing a book on the critical care of neurological conditions which will be of interest and use to both the neurologist and the non-neurologist.

The book covers neurotrauma and the major medical neurological emergencies. It also provides information on the diagnosis and investigation of neurological conditions which arise in the ITU patient, such as the "hard to wean" patient, critical illness polyneuropathy, and iatrogenic seizures.

The chapter on CNS trauma gives a clear review of current thought and practice in the management of head injury. Unfortunately the section on spinal trauma is too brief. This is an important area and I would have liked to see it treated in the same comprehensive man-

ner. In particular I feel more detail should have been included on the acute monitoring and management of the cardiorespiratory complications in spinal trauma, and the later presenting but potentially life threatening autonomic dysreflexia syndrome.

Subarachnoid haemorrhage, stroke, seizures, and Guillain-Barré syndrome are covered logically and with practical management suggestions. The differential diagnosis of encephalopathy is comprehensive, although of necessity in a book of this size coverage of the detailed management of specific conditions is limited. In particular there is a good short section on hypoxic-ischaemic encephalopathy.

The last section covers ethics. It is clearly written and covers such important areas as withdrawal of care and euthanasia; however, it is presented from a North American perspective and does not cover any of the recent English or Scottish case law.

Overall the book achieves an excellent balance of relevant physiology and monitoring, current practice, and the practical implementation of new research. There are suggestions throughout of work in progress on new therapeutic or neuroprotective agents, which makes it a pleasantly optimistic read. I recommend it to any trainee involved in the care of neurologically injured or ill patients. Its relevance to the A&E trainee comes from the clear explanation of the principles of treatment which form the basis for our emergency room management.

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Roberts' Practical Guide to Medical Emergencies. By James R Roberts. (Pp 302; £30.75.) Philadelphia: Lippincott-Raven, 1996. ISBN 0 397 51838 2.

Roberts' book constitutes part of the exponential growth in texts on emergency medicine. This book is a collection of essays written by a single author from the American publication *Emergency Medicine News*. The individual articles have been revised to bring them up to date and grouped into themed chapters. Many of the topics covered would

not be included in a British publication about "medical" emergencies, such as fingertip injuries, puncture wounds to the foot, and sedation of children. The title does not accurately indicate the contents of the book, though the author undoubtedly presents a practical guide based on personal practice, supported by references to the medical literature. The views expressed are well reasoned and highly readable in the main. However, readers expecting a comprehensive "guide to common medical emergencies" will be disappointed. The small range of topics discussed constitute a minor part of British A&E practice.

Some of the topics covered have stimulated considerable debate among my colleagues. One particularly contentious example is the recommendation for combined use of intravenous fentanyl and midazolam by non-anaesthetists to sedate children for painful or unpleasant procedures in the emergency department.

The chapter entitled "Myths and misconceptions" provides an interesting insight into some procedures that have long departed from UK practice. Examples include the use of iced gastric lavage for control of upper gastrointestinal haemorrhage and the routine use of figure of eight bandaging for clavicular fractures. Other mythologies exposed seem to have little relevance to practice on this side of the Atlantic, such as pouring scorn on the practice of using nebulised adrenaline to facilitate the discharge of children with croup from the emergency department.

In this brave new world of evidence based medicine, it is disappointing that this book is in essence a collection of personal opinions. While the individual articles are both interesting and entertaining they lack the rigour of systematic reviews and are not of great practical help in directing change in the management of individual patients.

In summary the book provides an interesting insight into the practice of a highly respected North American emergency physician but many of the views expressed are not readily applicable to the work of an A&E doctor in Britain. Colleagues looking for a "practical guide to medical emergencies" are advised to look elsewhere—perhaps closer to home?

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Correction

In the paper by O'Donnell *et al* in the May issue (volume 14, pages 163-4), some errors in table 1 were not corrected on proof. The corrected section of the table is as follows (corrected figures in bold):

- (4) It is important to rinse mouth out after steroid inhaler use. (*True*)
24/25 SHOs answered correctly
6/25 Nurses answered correctly
- (5) How can you tell that the MDI is empty? (*Shake it*)
14/25 SHOs answered correctly
19/25 Nurses answered correctly